MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG250 10-15-59 et

10699

10659

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TRappe-rural
c. LENGTH OF STAY IN 1b: 15 yrs.
d. NAME OF HOSPITAL OR INSTITUTION: Hambleton

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Trappe
d. STREET ADDRESS: Hambleton
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles; Middle: Arthur; Last: Bast

4. DATE OF DEATH: Month: Sept.; Day: 14; Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 20, 1884

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months; Days — IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retailer-ret.

10b. KIND OF BUSINESS OR INDUSTRY: Furniture Store

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Bast

14. MOTHER'S MAIDEN NAME: Molly Willis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: 217 30 8392

17. INFORMANT: Mrs. Carrie E. Bast, RD, Maryland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: < 1 hour

420.0

DUE TO (b): Arteriosclerotic heart disease — Several years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; o. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~I attended the deceased from~~ _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at ~~the hour stated~~ 4 P.M., from the causes and on the date stated above.

Pronounced dead at his home 4PM 9-14-59

ACTUAL SIGNATURE: Robert W. Trever, M.D. — ADDRESS (Street, city or town, state): 202 Dover St. — DATE SIGNED: 9-16-59

PHYSICIAN'S NAME (Type): Robert W. Trever, MD — Easton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/17/59

22c. NAME OF CEMETERY OR CREMATORY: Spring Hill Cemetery

22d. LOCATION (City, town, or county) (State): Easton, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: Easton, Md.

24a. REC'D BY REGISTRAR DATE: OCT 2 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krouse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10700

CERTIFICATE OF DEATH

Reg. Dist. No. 10660

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oxford
c. LENGTH OF STAY IN 1b: 5 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Tilghman Str

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New York
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New York City 69x-3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First WALTER Middle BENSEL Last

4. DATE OF DEATH: Month 9- Day 16 Year 1959

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 22, 1869

9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Doctor

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Brownlee Bensel

14. MOTHER'S MAIDEN NAME: Mary Maclay

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): 1917-1920

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Ralph H. Wiley Address: Oxford, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CEREBRAL VASCULAR ACCIDENT — INTERVAL BETWEEN ONSET AND DEATH: 48 HRS.

331X

DUE TO (b): ARTERIOSCLEROSIS — YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from APRIL 20, 1959, to SEPT. 16, 1959, that I last saw the deceased alive on SEPT. 16, 1959, and that death occurred at 10:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Donald F. Bartley M.D. ADDRESS (Street, city or town, state): 9 N. HANSON ST. DATE SIGNED: 9-16-59

PHYSICIAN'S NAME (Type): DONALD F. BARTLEY M.D. EASTON MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 18, 1959

22c. NAME OF CEMETERY OR CREMATORY: Oxford Cemetery

22d. LOCATION (City, town, or county) (State): Oxford, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Maurice E. Newnam & Son ADDRESS: Easton, Md.

24a. REC'D BY REGISTRAR DATE: SEP 23 '59

24b. REGISTRAR'S SIGNATURE: Adams & Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10701

CERTIFICATE OF DEATH

Reg. Dist. No. 11833

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsburg
c. LENGTH OF STAY IN 1b: 4 mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Rt 4, Box 142, EASTON

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsburg
d. STREET ADDRESS: Rt. 4, Box 142, EASTON
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First VENUS Middle POE Last BLAKE

4. DATE OF DEATH: Month 9 Day 22 Year 1959

5. SEX: GIRL

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/19/59

9. AGE (In years last birthday): 4 MOS.
IF UNDER 1 YEAR: Months 4 Days 3
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): EASTON, Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: CHARLES EDWARD BLAKE

14. MOTHER'S MAIDEN NAME: BARBARA ANN DAVIDSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ✓ (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ✓

17. INFORMANT: MOTHER — Address: Rt 4, Box 142, EASTON

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
491X
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 3 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 17, 1959 to Sept. 21, 1959, that I last saw the deceased alive on Sept. 21, 1959, and that death occurred at 5 a. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Shepard Krech JR M.D.
ADDRESS (Street, city or town, state): Easton Maryland
DATE SIGNED: 9/23/59
PHYSICIAN'S NAME (Type): Shepard Krech JR

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 9/59
22c. NAME OF CEMETERY OR CREMATORY: Williamsburg
22d. LOCATION (City, town, or county) (State): Williamsburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James B. Hadley ADDRESS: 426 Dover St, Easton

24a. REC'D BY REGISTRAR DATE: OCT 13 '59
24b. REGISTRAR'S SIGNATURE: Curtis L. Kraus

2080214XV3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG249 10-9-59 et

10676

CERTIFICATE OF DEATH

Reg. Dist. No. 10661

1. PLACE OF DEATH
a. COUNTY Talbot
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
c. LENGTH OF STAY IN 1b Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 112 talbot La.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton,
d. STREET ADDRESS 112 Talbot Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First LAURA Middle A Last Breese

4. DATE OF DEATH Month 9 Day 23 Year 1959

5. SEX Female
6. COLOR OR RACE Col
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH 12-4-1871 1878
9. AGE (In years last birthday) 80 yrs.
IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook
10b. KIND OF BUSINESS OR INDUSTRY Domestic
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph Murray
14. MOTHER'S MAIDEN NAME Catherine Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Blanche M. Rudd, Address New York.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombus — INTERVAL BETWEEN ONSET AND DEATH: acute
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Hypertensive Arteriosclerotic
DUE TO (c) Cardiovascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Obesity
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/22, 1957 to 7/23, 1959, that I last saw the deceased alive on 7/28, 1959, and that death occurred at 1:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE L. J. Eseder M.D.
ADDRESS (Street, city or town, state) 12 N. Hanson St
DATE SIGNED
PHYSICIAN'S NAME (Type) L. J. Eseder MD Easton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9/1/59
22c. NAME OF CEMETERY OR CREMATORY Richardes Cem
22d. LOCATION (City, town, or county) (State) Easton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE James L. Parsell ADDRESS Easton, Md.
24a. REC'D BY REGISTRAR DATE OCT 1 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Kunes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10677 Items 11,12, see birth Cert. et

Reg. Dist. No. 10662

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 24
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: ~~Kent~~ Q.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Church Hill
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First: Nora — Middle: Ann — Last: Cannon

4. DATE OF DEATH: Month: Sept. — Day: 5 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 2, 1944

9. AGE (In years last birthday): 15 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Chestertown, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Clarence W. Cannon

14. MOTHER'S MAIDEN NAME: Mildred McMullen.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Father — Address: as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: > 6 mos.

592X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Chronic glomerulonephritis — 4+ years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-13, 1959, to 8-5, 1959, that I last saw the deceased alive on 9-4, 1959, and that death occurred at 9:25 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W. Trever, M.D. — ADDRESS (Street, city or town, state): 202 Dover St. — DATE SIGNED: 9-5-59

PHYSICIAN'S NAME (Type): ROBERT W. TREVER — Easton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 9/8/59 — 22c. NAME OF CEMETERY OR CREMATORY: [illegible] — 22d. LOCATION (City, town, or county) (State): Church Hill, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L Lane — ADDRESS: Church Hill Md

24a. REC'D BY REGISTRAR DATE: SEP 9 '59 — 24b. REGISTRAR'S SIGNATURE: [illegible]

Arthur L Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10678 **CERTIFICATE OF DEATH** 15663

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GLEN BURNIE
d. STREET ADDRESS: 115 Second Ave, S.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RICHARD Middle Leroy Last CORKRAN
4. DATE OF DEATH: Month September Day 9 Year 1959
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: AUG. 12, 1883
9. AGE (In years last birthday): 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TEACHER (Ret.)
10b. KIND OF BUSINESS OR INDUSTRY: A-A Co. Bd. of Ed.
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JOHN CORKRAN
14. MOTHER'S MAIDEN NAME: AUGUSTA DAVIS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: WIFE - MRS. JETTA CORKRAN Address: Glen Burnie MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 493X
DUE TO (b): pneumonia — 4 days.
DUE TO (c): cachexia - severe
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): anemia, chronic prostate hypertrophy
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-1, 1959 to 9-9, 1959 that I last saw the deceased alive on 9-9, 1959, and that death occurred at 3:45 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Harry M Reese Jr M.D. — ADDRESS (Street, city or town, state): St Michaels Md — DATE SIGNED: 9-9-59
PHYSICIAN'S NAME (Type): Harry M Reese Jr

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12 Sept. 1959
22c. NAME OF CEMETERY OR CREMATORY: Meadowridge Mem. Pk.
22d. LOCATION (City, town, or county) (State): Howard Co. Maryland
23. FUNERAL DIRECTOR'S SIGNATURE: Robert P. Ware — ADDRESS: Glen Burnie Md
24a. REC'D BY REGISTRAR DATE: SEP 11 '59
24b. REGISTRAR'S SIGNATURE: Arthur L Kraus

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10664

CERTIFICATE OF DEATH

10679 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH — a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 7 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: EASTON Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) — a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
d. STREET ADDRESS: " "Waverly" "
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MRS. Middle: Barbara Last: F. Davidson
4. DATE OF DEATH: Month: Sept Day: 7 Year: 19 59

5. SEX: Fe
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov 1, 1882
9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Giddion White
14. MOTHER'S MAIDEN NAME: Julia Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs Dan W Muny Address: Easton Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): A-H-D
420.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 7 mo

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Ca of uterus c invasion of bladder
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 1952 to 7/29/59, that I last saw the deceased alive on 7/29/59, 19, and that death occurred at 9 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): Easton, Md DATE SIGNED:

PHYSICIAN'S NAME (Type): Doctor P. E. Cox Easton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: Sept 9 1959
22c. NAME OF CEMETERY OR CREMATORY: Spring Hill
22d. LOCATION (City, town, or county) (State): Easton Md

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] ADDRESS: Easton Md

24a. REC'D BY REGISTRAR DATE: SEP 10 '59
24b. REGISTRAR'S SIGNATURE: Arthur S Kunes

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10702

CERTIFICATE OF DEATH

Reg. Dist. No. 10665

1. PLACE OF DEATH
a. COUNTY Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford
c. LENGTH OF STAY IN 1b 4 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford
d. STREET ADDRESS Oxford
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First James Middle J. Last Duncan
4. DATE OF DEATH Month Sept Day 11 Year 19 59
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH July 4 1875
9. AGE (In years last birthday) 84 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY Waterman
11. BIRTHPLACE (State or foreign country) Dorchester County Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas G. Duncan
14. MOTHER'S MAIDEN NAME Rosa Dise
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mary P. Duncan. Address Oxford Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 4 hrs
DUE TO (b) Arteriosclerosis — Cerebral — 4 yrs.
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/24, 19 59, to 9/11, 19 59, that I last saw the deceased alive on 9/11, 19 59, and that death occurred at 2 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE L. J. Egleder M.D. — ADDRESS (Street, city or town, state) 12 N. Hanson St — DATE SIGNED
PHYSICIAN'S NAME (Type) L. J. EGLESEDER MD — EASTON, MD

22a. BURIAL, CREMATION, REMOVAL (Specify) — 22b. DATE THEREOF Sept 14 59 — 22c. NAME OF CEMETERY OR CREMATORY Oxford — 22d. LOCATION (City, town, or county) Oxford (State) Md
23. FUNERAL DIRECTOR'S SIGNATURE Keller Bros — ADDRESS Easton
24a. REC'D BY REGISTRAR DATE SEP 18 59 — 24b. REGISTRAR'S SIGNATURE Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/56

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 14158

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
c. LENGTH OF STAY IN 1b 42 hr
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last English
4. DATE OF DEATH Month Sept. Day 21 Year 1959

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 09/19/59
9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Sidney C. English
14. MOTHER'S MAIDEN NAME Hannelore Braun

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mr Sidney C. English Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Failure

773.5

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Prematurity

DUE TO

(c) [illegible]

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 9/19, 1959, to 9/21, 1959, that I last saw the deceased alive on 9/21, 1959, and that death occurred at 12 [illegible]M, from the causes and on the date stated above.

ACTUAL SIGNATURE [signature] M.D.
ADDRESS (Street, city or town, state) Federalsburg Md
DATE SIGNED 12/8/59

PHYSICIAN'S NAME (Type) H TRAPNELL

22a. BURIAL, CREMATION, REMOVAL (Specify) Incineration
22b. DATE THEREOF 10/1/59
22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital
22d. LOCATION (City, town, or county) Easton (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE None
ADDRESS Body incinerated
24a. REC'D BY REGISTRAR DATE DEC 14 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2000 0594 X 12

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10666

CERTIFICATE OF DEATH

10680 Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY TALBOT MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON

c. LENGTH OF STAY IN 1b 3 YRS.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FEDERALSBURG

d. STREET ADDRESS W. CENTRAL AVE.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First CLARENCE Middle LEE Last FLUHARTY

4. DATE OF DEATH Month SEP. Day 18 Year 1959

5. SEX M

6. COLOR OR RACE W

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH DEC. 29, 1910

9. AGE (In years last birthday) 48 yrs.

IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ICE PLANT OPR.

10b. KIND OF BUSINESS OR INDUSTRY POULTRY

11 BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY? U S A.

13. FATHER'S NAME IRA N. FLUHARTY

14 MOTHER'S MAIDEN NAME ANNIE JESTER

15. WAS DECEASED EVER IN U. S ARMED FORCES? (Yes no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-10-2036

17. INFORMANT Address MARY E. FLUHARTY FEDERALSBURG

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cachexia — INTERVAL BETWEEN ONSET AND DEATH Jan 1959

153.8

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Carcinoma of Colon. Dec 1958

DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec, 1958, to 9/18, 1959, that I last saw the deceased alive on 9/17, 1959, and that death occurred at 1:25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE J.T.B Ambler M.D. ADDRESS (Street, city or town, state) Box 96 Easton Md. DATE SIGNED

PHYSICIAN'S NAME (Type) Dector J.T.B.Ambler Box 96 Easton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Sept.21, 1959

22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery

22d LOCATION (City, town, or county) (State) Federalsburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.J. Trainpoon Son Federalsburg Md

24a. REC'D BY REGISTRAR DATE SEP 28 '59

24b. REGISTRAR'S SIGNATURE Allen S Knuse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) ISM 9/55

I

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10681 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10667

Reg. Dist. No.

1. PLACE OF [redacted] a. COUNTY: TALBOT — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY: TALBOT
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON — c. LENGTH OF STAY IN 1b: 37 hrs. 5 min	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Easton Memorial Hospital	d. STREET ADDRESS: R.F.D #2 — e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print)	First: Robert — Middle: J. — Last: Foster II
4. DATE OF DEATH	Month: Sept — Day: 28 — Year: 1959
5. SEX	Male
6. COLOR OR RACE	White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	
8. DATE OF BIRTH	Feb 28, 1941
9. AGE (In years last birthday)	18 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	FARMING
10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)	Delaware
12. CITIZEN OF WHAT COUNTRY?	U.S.A.
13. FATHER'S NAME	Robert J. Foster Sr.
14. MOTHER'S MAIDEN NAME	Mary Ragener
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.	
17. INFORMANT — Address	Robert J. Foster, Sr., father – same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe head injury — INTERVAL BETWEEN ONSET AND DEATH: 37 hrs

DUE TO (b) Auto accident

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Speeding – car turned over

20c. TIME OF INJURY: Hour 6:50 p.m. — Month, Day, Year: 9-26 1959

20d. INJURY OCCURRED: While at work [ ] Not while at work [X]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rte 662

20f. (City or town) nr EASTON (County) TAL (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Louis Melty M.D.

[redacted] NAME (Type): MELTY

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

DATE SIGNED: 9-28-59

RC 9:05 AM

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: Oct 1, 1959	22c. NAME OF CEMETERY OR CREMATORY: Mt. Pleasant Cem	22d. LOCATION (City, town, or county) (State): Easton Md.
23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: Easton, Md.	24a. REC'D BY REGISTRAR DATE OCT 2 '59	24b. REGISTRAR'S SIGNATURE: [illegible]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10703 **CERTIFICATE OF DEATH** Reg. Dist. No. 10669

1. PLACE OF DEATH a. COUNTY [redacted] Talbot MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Wye Mills
c. LENGTH OF STAY IN 1b 1 hr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION [redacted]

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Q.A.
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Rural - Wye Mills
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First William Middle Henry Last Griffin
4. DATE OF DEATH Month Sept. Day 1 Year 1959
5. SEX M
6. COLOR OR RACE C
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 10/1/07
9. AGE (In years last birthday) 51 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Lee Griffin
14. MOTHER'S MAIDEN NAME Frances Homer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO
INFORMANT Gertrude Brown Address - Queen Annes

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 1 hr.
420.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 19 59 to Sept. 19 59 that I last saw the deceased alive on Aug 31, 19 59, and that death occurred at 11 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE Irwin C. Hoyt M.D. ADDRESS (Street, city or town, state) Queenstown Md. DATE SIGNED 9/2/59
PHYSICIAN'S NAME (Type) Irwin C. Hoyt MD

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9/6/59
22c. NAME OF CEMETERY OR CREMATORY Richards, Cem.
22d. LOCATION (City, town, or county) (State) Easton Md.

23. FUNERAL DIRECTOR'S SIGNATURE James H. Caulk ADDRESS Caulk, Easton, Md.
24a. REC'D BY REGISTRAR DATE SEP 8 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10682

CERTIFICATE OF DEATH

10671

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be related by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Talbot
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 3 mons.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Linden Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton, Md.
d. STREET ADDRESS: Linden Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alice Middle: Sybilla Last: Hoffheins

4. DATE OF DEATH: Month: Sept. Day: 12 Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 19, 1877

9. AGE (In years last birthday): 82 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework

10b. KIND OF BUSINESS OR INDUSTRY: housewife

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Harvey T. Cushwa

14. MOTHER'S MAIDEN NAME: Laura Virginia Stuckey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): none

16. SOCIAL SECURITY NO: 577 50 1080

17. INFORMANT: Address: Mrs. Virginia C. Rauch, Easton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): CARCINOMA of the UTERUS — INTERVAL BETWEEN ONSET AND DEATH: 3 YRS.

DUE TO (b): & METASTASES

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from AUG. 31 19 59 to SEPT. 12 19 59 that I last saw the deceased alive on SEPT. 12 19 59 and that death occurred at 9:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Donald F. Bartley M.D. ADDRESS (Street, city or town, state): 9 N. HANSON ST. EASTON, MD. DATE SIGNED: 9-12-59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/15/59

22c. NAME OF CEMETERY OR CREMATORY: Greenhill Cemetery

22d. LOCATION (City, town, or county) (State): Martinsburg, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: C. C. Frampton, Coroner ADDRESS: Easton, Md.

24a. REC'D BY REGISTRAR DATE: OCT 2 '59

24b. REGISTRAR'S SIGNATURE: Clifton S. Kraus

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10704 **CERTIFICATE OF DEATH** Reg. Dist. No. 10672

1 PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland b. COUNTY: Talbot

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bozman, Md.
c. LENGTH OF STAY IN 1b: 40 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bozman, Maryland

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ----

d STREET ADDRESS: ----

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle H. Last HUTSON

4. DATE OF DEATH: Month September Day 18, Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: Nov. 12, 1878

9. AGE (In years last birthday): 80 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman

10b. KIND OF BUSINESS OR INDUSTRY: Seafood

11 BIRTHPLACE (State or foreign country): Centreville, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Hutson

14. MOTHER'S MAIDEN NAME: Frances Ann Irland

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ----

16 SOCIAL SECURITY NO:

17. INFORMANT Address: Francis Hutson, Bozman, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.

163X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cor pulmonale — 6 mos.

DUE TO (c): Adenocarcinoma lung - c

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Metastases. Cachexia generalized.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-18-'58 to 9-18-'59 that I last saw the deceased alive on 9-18-'59, and that death occurred at 4 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Henry Reed Jr M.D. ADDRESS (Street, city or town, state): St Michaels Md DATE SIGNED: 9-19-59

PHYSICIAN'S NAME (Type): Henry Reed Jr

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: Sept21,1959

22c NAME OF CEMETERY OR CREMATORY: Christ Churchyard

22d. LOCATION (City town, or county) (State): St. Michaels, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: L. Hamilton Harrison, St. Michaels, Md

24a. REC'D BY REGISTRAR DATE: SEP 23 '59

24b REGISTRAR'S SIGNATURE: Arthur B. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10683 **CERTIFICATE OF DEATH** 10673

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1 PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 3 days.
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Neavitt Md.
d STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Nellie — Middle O — Last Jones
4. DATE OF DEATH: Month Sept. — Day 27 — Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 3 1898.
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hse.
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Md
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John T Harrison
14 MOTHER'S MAIDEN NAME: Susan McQuay

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service): —
16 SOCIAL SECURITY NO: none
17 INFORMANT: Samuel C. Jones — Address: Neavitt Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

175.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): cachexia severe — 1 yr.

DUE TO (c): adenocarcinoma ovary

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): c widespread abd. metastases

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 1955 19____, to 9-22 1959 that I last saw the deceased alive on 9-22, 1959, and that death occurred at 2:10 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas Reeves M.D. — ADDRESS (Street, city or town, state): St Michaels Md — DATE SIGNED

PHYSICIAN'S NAME (Type): Guy M Reeves Jr — 9-26-59

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: Sept 29, 1959
22c. NAME OF CEMETERY OR CREMATORY: Neavitt Cemetery
22d. LOCATION (City, town, or county): Neavitt (State): Md

23 FUNERAL DIRECTOR'S SIGNATURE: Hamilton Harrison — ADDRESS: St Michaels Md.
24a. REC'D BY REGISTRAR DATE: OCT 1 '59
24b REGISTRAR'S SIGNATURE: Arthur A Harris

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10684 **CERTIFICATE OF DEATH** 10674

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 46 min
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Newcomb
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Boy — Last: Marshall

4. DATE OF DEATH: Month: September — Day: 22 — Year: 1959

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 22, 1959

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR — Months: — Days: — IF UNDER 24 HRS. — Hours: — Min: 46

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Albert Marshall, Sr.

14. MOTHER'S MAIDEN NAME: Irene Faulkner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT — Address: Mother -

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Bilateral renal agenesis

DUE TO (b): Sub-dural hemorrhage

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Foraton cerebelli tentorii

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from [illegible], 19____, to [illegible], 19____, that I last saw the deceased alive on [illegible], 19____ and that death occurred at 7:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): 219 S. Washington St. Easton Md. DATE SIGNED: 24 Sept. 59

PHYSICIAN'S NAME (Type): E. C. H. Schmidt

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept 24, 1959

22c. NAME OF CEMETERY OR CREMATORY: Christ Cemetery

22d. LOCATION (City, town, or county) (State): St. Michaels Md

23. FUNERAL DIRECTOR'S SIGNATURE: J. Hamilton Harrison — ADDRESS: St. Michaels Md.

24a. REC'D BY REGISTRAR DATE: SEP 28 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 1SM 9/55

2080 393XU 3

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10685

CERTIFICATE OF DEATH

10676

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Easton Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: TALBOT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Queen Anne
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Mr. Middle: Bernard W. Last: Messix

4. DATE OF DEATH: Month: Sept Day: 1 Year: 19 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct 22, 1890
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Mr Byard Messix
14. MOTHER'S MAIDEN NAME: Emma Taylor.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: W.B. Messix Jr. (Son) Address: Queen Anne, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Massive gastric hemorrhage — INTERVAL BETWEEN ONSET AND DEATH
462.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Occlusion
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on Pathologist 19____, and that death occurred at 2 p. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E.C.H. Schmidt M.D. ADDRESS (Street, city or town, state): 216 S. Washington Ave Easton Md DATE SIGNED: 3 Sept 59

PHYSICIAN'S NAME (Type): E.C.H. Schmidt Easton Md Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11/4/59
22c. NAME OF CEMETERY OR CREMATORY: St. Joseph's Cemt.
22d. LOCATION (City, town, or county) (State): Cordova, R.D., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W. Hampton ADDRESS: Capel, Easton Md
24a. REC'D BY REGISTRAR: OCT 2 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,,14 FilmG249 10-9-59 et

CERTIFICATE OF DEATH

10686 — Reg. Dist. No. 10677

1. PLACE OF DEATH
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: TALBOT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
d STREET ADDRESS: 12 PARK ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print): First RAYMOND Middle Last MILES

4. DATE OF DEATH: Month September Day 23 Year 19 59

5. SEX: MALE
6. COLOR OR RACE: NEGRO
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MARCH 19, 1891
9. AGE (In years last birthday): 68 yrs
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months, Days, Hours, Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14 MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16 SOCIAL SECURITY NO
17. INFORMANT: MARGARET LEWIS-DRUG. Address: EASTON, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia
590X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Acute and Chronic Glomerulonephritis
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic cardiovascular disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 19 59 to Sep 23, 19 59, that I last saw the deceased alive on Sep 23, 19 59, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L. G. Eglseder M.D. ADDRESS (Street, city or town, state): 12 N. Hanson St. DATE SIGNED

PHYSICIAN'S NAME (Type): EASTON MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-27-59
22c. NAME OF CEMETERY OR CREMATORY: Ivy Town Cem.
22d LOCATION (City, town, or county) (State): Rt. # 3, Easton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James B. Dashiell, Easton, Md
24a. REC'D BY REGISTRAR DATE OCT 1 '59
24b REGISTRAR'S SIGNATURE: Arthur E. Rhoads

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

X X 1 M

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10678

10705 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Talbot MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON rural
c. LENGTH OF STAY IN 1b DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md b. COUNTY Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON
d. STREET ADDRESS Rural
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First: Ruth Middle: Newbaker Last:
4. DATE OF DEATH Month: 9 Day: 27 Year: 1959

5. SEX F
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH MAY-6, 1902
9. AGE (In years last birthday) 57 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME James L. Marten
14. MOTHER'S MAIDEN NAME Anna Brewster Kinnack

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO —
17. INFORMANT Mrs. Barbara Firth Address: Easton Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Comp. fract. skull - Fract. cerv. spine
835X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Auto accident
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a.m. p.m. Month, Day, Year: 9-27 1959
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) farm lane
20f. (City or town) Easton (County) Talbot (State) Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from. Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Louis Welty M.D
EXAMINER'S NAME (Type) WELTY HAROLD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 9-27-59

22a. BURIAL, CREMATION, REMOVAL Cremation
22b. DATE THEREOF 9/30/59
22c. NAME OF CEMETERY OR CREMATORY Glen Black Crem
22d. LOCATION (City or town, State) Philadelphia Penna.

23. FUNERAL DIRECTOR'S SIGNATURE Norma E. Meconum Dir
ADDRESS Easton Md
24a. REC'D BY REGISTRAR DATE OCT 2 '59
24b. REGISTRAR'S SIGNATURE Arthur H. Hines

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

Item 8 Filed 249 10-4-59 et

CERTIFICATE OF DEATH

10706 — Reg. Dist. No. 10679

1 PLACE OF DEATH — COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cordova
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: md — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cordova
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Elijah — Middle: — Last: Newnman
4. DATE OF DEATH: Month: 9 — Day: 24 — Year: 1959

5. SEX: male
6. COLOR OR RACE: Col
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/9/1891
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS — Months / Days / Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm
10b. KIND OF BUSINESS OR INDUSTRY: Farmer Lab.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Elijah Newnman Sr.
14. MOTHER'S MAIDEN NAME: Clara Dobson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 213-14-1344
17. INFORMANT — Address: Estella Newnman, Cordova md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive heart failure
DUE TO (b): Coronary atherosclerotic heart disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Years / Months / Days / Hours / Min: ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August, 19 59, to Sept, 19 59, that I last saw the deceased alive on August, 19 59, and that death occurred at 11 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph E Johnson III M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED:
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-27-59
22c. NAME OF CEMETERY OR CREMATORY: Old Chapel Cem
22d. LOCATION (City, town, or county) (State): Cordova md.

23. FUNERAL DIRECTOR'S SIGNATURE: James L Shiell
ADDRESS: Easton, md.
24a. REC'D BY REGISTRAR DATE: OCT 1 '59
24b. REGISTRAR'S SIGNATURE: Clarence E. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be related by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10687 Reg. Dist. No. 10680

1. PLACE OF DEATH
a. COUNTY Talbot MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
c. LENGTH OF STAY IN 1b 9 days
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely RURAL
d STREET ADDRESS NONE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First William Middle J Last Nichols
4. DATE OF DEATH Month September Day 23 Year 1959
5. SEX M
6. COLOR OR RACE C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH March 29 1885
9. AGE (In years last birthday) 74 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME J. W Nichols
14. MOTHER'S MAIDEN NAME Lizzie Jackson.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO 218-30-0884A
17. INFORMANT Address wife - Mary Nichols Ridgely Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebral thrombosis, right — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Recent prostatectomy prostatectomy
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from [illegible] 19___ to ___ 19___ that I last saw the deceased alive on ___ 19___ and that death occurred at 4:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE E. C. H. Schmidt M.D. ADDRESS (Street, city or town, state) 219 S Washington St. Easton Md. DATE SIGNED 9-24-59
PHYSICIAN'S NAME (Type) E. C. H. Schmidt Easton 16, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9-26-59
22c. NAME OF CEMETERY OR CREMATORY Unitarian
22d. LOCATION (City, town, or county) (State) Easton Maryland

23. FUNERAL DIRECTOR'S SIGNATURE T. E. Boulais ADDRESS Preston, Md
24a. REC'D BY REGISTRAR DATE SEP 29 '59
24b. REGISTRAR'S SIGNATURE Clarence H. Evans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10707

CERTIFICATE OF DEATH

Reg. Dist. No. 10681

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tilghman
c. LENGTH OF STAY IN 1b: 20 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ----

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tilghman
d. STREET ADDRESS: ----
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle Lee Last PHILLIPS

4. DATE OF DEATH: Month September Day 16, Year 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 9, 1912

9. AGE (In years last birthday): 47 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (State or foreign country): St. Michaels, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Walton A. Hause

14. MOTHER'S MAIDEN NAME: Hattie G. Kraft

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO: — —

17. INFORMANT: Kennedy L. Phillips, Tilghman, Md.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cancer Stone — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO (b): ~
DUE TO (c): ~
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month ~ Day, Year 19 ~ Hour o. m. p. m

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) ~ (County) (State)

21. I certify that I attended the deceased from June, 19 59, to Sept 16, 19 59, that I last saw the deceased alive on Sept 15, 19 59, and that death occurred at 11 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Clayton Reese M.D.
ADDRESS (Street, city or town, state): Tilghman Md
DATE SIGNED:
PHYSICIAN'S NAME (Type): CLAYTON REESER Sr TILGHMAN Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 18, 1959
22c. NAME OF CEMETERY OR CREMATORY: Tilghman Cemetery
22d. LOCATION (City, town, or county) (State): Tilghman, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Hampton Harrison, St. Michaels md
ADDRESS

24a. REC'D BY REGISTRAR DATE: SEP 21 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10688

CERTIFICATE OF DEATH

10682 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY TALBOT MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON
c. LENGTH OF STAY IN 1b 12 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY TALBOT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
d. STREET ADDRESS 49 Pleasant St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Denise Middle Hereneg Last Rasin
4. DATE OF DEATH Month Sept Day 17 Year 1959
5. SEX F.
6. COLOR OR RACE Cl.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Aug 14, 1959
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months 1 Days 3
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Infant
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Hermione Rasin
14. MOTHER'S MAIDEN NAME CORA. Chase

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Address CORA Rasin mother — Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Obstruction of gastric outlet
1120 DUE TO (b) Malnutrition
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19____, to ____, 19____, that I last saw the deceased alive on Sept 17, 19 59, and that death occurred at 7:20 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE [signature] M D
ADDRESS (Street, city or town, state) 21 [illegible]
DATE SIGNED
PHYSICIAN'S NAME (Type) E. C. [illegible]

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9/19/59
22c. NAME OF CEMETERY OR CREMATORY Rubenstein Cem.
22d. LOCATION (City, town, or county) (State) Easton Md.

23. FUNERAL DIRECTOR'S SIGNATURE [signature] ADDRESS Gabriel Easton, Md.
24a. REC'D BY REGISTRAR DATE OCT 1 '59
24b. REGISTRAR'S SIGNATURE Arthur [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

208182XU3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10683

CERTIFICATE OF DEATH

10689 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: TALBOT
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Queenanne
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CENTREVILLE,
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First JEAN Middle DENISE Last RYANS

4. DATE OF DEATH: Month SEPTEMBER Day 2 Year 1959

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 16, 1958

9. AGE (In years last birthday): _ yrs.
IF UNDER 1 YEAR: Months 1 Days 12
IF UNDER 24 HRS.: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: WILLIAM L. RYANS

14. MOTHER'S MAIDEN NAME: GERTRUDE GROSS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Meidosis
DUE TO (b): Marasmus
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 172.0

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from _____ to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph Schmidt M.D.
ADDRESS (Street, city or town, state): 219 S. Washington ST. Easton Md.
DATE SIGNED: 2 Sept 59
PHYSICIAN'S NAME (Type): F. C. H. Schmidt

22a. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify): Burial

22b. DATE THEREOF: Sept. 3 1959

22c. NAME OF CEMETERY OR CREMATORY: Centreville Cemetery

22d. LOCATION (City, town, or county) (State): Rural Centreville Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: James H. Bates Jr. ADDRESS: Bates Bros Centreville Md.

24a. REC'D BY REGISTRAR DATE: SEP 4 '59

24b. REGISTRAR'S SIGNATURE: Charles L Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2180234 X V3

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10690 **CERTIFICATE OF DEATH** Reg. Dist. No. 10684

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Talbot
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Denton
d. STREET ADDRESS: RFD #3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Addie Middle — Last Seth.

4. DATE OF DEATH: Month September Day 9 Year 1959

5. SEX: F

6. COLOR OR RACE: Col

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 1, 1889

9. AGE (In years last birthday): 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Faulkner

14. MOTHER'S MAIDEN NAME: Harriett Johnson.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas — INTERVAL BETWEEN ONSET AND DEATH

15 1/x

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/18, 19 59, to 9/9, 19 59, that I last saw the deceased alive on 9/9, 19 59, and that death occurred at 10P M, from the couses ond on the date stated above.

ACTUAL SIGNATURE: Arthur B. Cecil, M.D. ADDRESS (Street, city or town, state): EASTON MD DATE SIGNED: 9/15/59

PHYSICIAN'S NAME (Type): ARTHUR B CECIL

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept 13, 1959

22c. NAME OF CEMETERY OR CREMATORY: Springrove

22d. LOCATION (City, town, or county) (State): Denton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Virgil Moore Son Denton, Md.

24a. REC'D BY REGISTRAR DATE SEP 21 '59

24b. REGISTRAR'S SIGNATURE: Arthur L Travis

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10691 **CERTIFICATE OF DEATH** 10685

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Talbot MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
c. LENGTH OF STAY IN 1b 9hrs 25 min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton
d. STREET ADDRESS RFD
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First George Middle Edward Last Sherwood
4. DATE OF DEATH Month September Day 18 Year 1959

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH November 15, 1899
9. AGE (In years last birthday) 59 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farming
11 BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John W. Sherwood
14 MOTHER'S MAIDEN NAME Anna Rettalick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NONE
16 SOCIAL SECURITY NO 214 28 1357
17. INFORMANT Address Anna Ruth Sherwood, Denton, R.D., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH 2 years.

DUE TO (b) Chronic glomerulonephritis — Unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m Month Day Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from _____, 19____ to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 2:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Robert W. Trever M.D. ADDRESS (Street, city or town, state) 202 Dover St. DATE SIGNED 9-18-59

PHYSICIAN'S NAME (Type) Robert W. TREVER Easton Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9/21/59
22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery
22d. LOCATION (City, town, or county) (State) Easton, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE W. Hampton Coard ADDRESS Easton, Md.
24a. REC'D BY REGISTRAR DATE OCT 2 '59
24b REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10692

10686

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Talbot MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Mac Middle Last Smith

4. DATE OF DEATH Month September Day 18 Year 1959

5. SEX Male

6. COLOR OR RACE Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Jan 6 1895

9. AGE (In years last birthday) 64 yrs.

IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10b. KIND OF BUSINESS OR INDUSTRY Factory

11. BIRTHPLACE (State or foreign country) Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME George Smith

14. MOTHER'S MAIDEN NAME Mary Roberts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: Hours

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Hypertensive Cardiovascular Disease — Years

DUE TO (c) Arteriosclerotic Heart Disease — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 18, 1957, to Sept 18, 1959, that I last saw the deceased alive on Sept 18, 1959, and that death occurred at 4:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE S Kroch Jr M.D. ADDRESS (Street, city or town, state) Easton, Md DATE SIGNED 9.22.59

PHYSICIAN'S NAME (Type) Shepard Kroch Jr

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 9-11-59

22c. NAME OF CEMETERY OR CREMATORY Williamsburg Cem.

22d. LOCATION (City, town, or county) (State) Rt. # 2, Easton, Md.

23 FUNERAL DIRECTOR'S SIGNATURE Thomas B Nabb ADDRESS Easton Md.

24a. REC'D BY REGISTRAR DATE OCT 1 '59

24b. REGISTRAR'S SIGNATURE Arthur H Kunes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10693 Item 11 [illegible] 10-7-59

CERTIFICATE OF DEATH

Reg. Dist. No. 10687

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 9½ hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Cordova
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Viola — Middle: R. — Last: Stanford

4. DATE OF DEATH: Month: September — Day: 1 — Year: 1959

5. SEX: Fe

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 28 1959

9. AGE (If over 1 year last birthday) yrs.

IF UNDER 1 YEAR: Months: 6 — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Talbot Co., Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: LeRoy Stanford

14. MOTHER'S MAIDEN NAME: Betty Louise Davidson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Asphyxia

DUE TO

0534

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from [illegible], 19____, to [illegible], 19____, that I last saw the deceased alive on [illegible], 19____, and that death occurred at 9:46 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): 295 S. Washington St. Easton Md. DATE SIGNED: Sept 1 59

PHYSICIAN'S NAME (Type): E. C. H. Schmidt

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE: James B. Penfield — ADDRESS: Easton Md

24a. REC'D BY REGISTRAR DATE SEP 14 '59

24b. REGISTRAR'S SIGNATURE: Clifton J. Kenna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2080 152 XU4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10694 **CERTIFICATE OF DEATH** Reg. Dist. No. 10688

1. PLACE OF DEATH
a. COUNTY Talbot MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
c. LENGTH OF STAY IN 1b 2 hrs 20 min

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hospital
d. STREET ADDRESS P.O. Box 607
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First Mr. Middle Clarence Last Stewart
4. DATE OF DEATH Month Sept Day 18 Year 1959

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Sept 30 1879
9. AGE (In years last birthday) 79 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY Printing
11. BIRTHPLACE (State or foreign country) Maryland.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME John A. Stewart
14. MOTHER'S MAIDEN NAME Mary C. Bond.

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 053-09-0647
17. INFORMANT Corine Wadsworth, daughter Address care

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH < 6 hours

DUE TO (b) Cerebral arteriosclerosis — Unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 18, 1959, to Sept. 18, 1959, that I last saw the deceased alive on Sept. 18, 1959, and that death occurred at 12:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Robert W. Trever M.D. ADDRESS (Street, city or town, state) 202 Dover St. DATE SIGNED 9-19-59

PHYSICIAN'S NAME (Type) Robert W. Trever Easton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF Sept 21, 1959
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln
22d. LOCATION (City, town or county) Washington (State) D.C.

23. FUNERAL DIRECTOR'S SIGNATURE [signature] ADDRESS Easton Md
24a. REC'D BY REGISTRAR DATE SEP 21 '59
24b. REGISTRAR'S SIGNATURE [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10708 **CERTIFICATE OF DEATH** 10689

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - St. Michaels
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ----

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural - St. Michaels
d. STREET ADDRESS: ----
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNIE Middle CORDELIA Last THOMAS

4. DATE OF DEATH: Month September Day 16, Year 1959

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 18,1875

9. AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (State or foreign country): St. Michaels, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Gates

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO: None

17. INFORMANT Address: William J. Thomas, St. Michaels, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 3 wks

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): atherosclerotic cerebrovascular disease —
DUE TO (c): ---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): cerebral hemorrhage-14 days.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-26, 19 59 to 9-14, 19 59, that I last saw the deceased alive on 9-14, 19 59, and that death occurred at 2 45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Guy M Reeder Jr MD — ADDRESS (Street, city or town, state): St Michaels md — DATE SIGNED

PHYSICIAN'S NAME (Type): Guy M Reeder Jr — 9-19-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept 20,,959

22c. NAME OF CEMETERY OR CREMATORY: Thomas Mem. Cemetery

22d. LOCATION (City, town, or county) (State): St. Michaels, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: S. Hamilton Harrison St Michael md.

24a. REC'D BY REGISTRAR DATE: SEP 23 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Number 9 10-1-59 et

CERTIFICATE OF DEATH

10695

10691 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Talbot
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
c. LENGTH OF STAY IN 1b 18 Mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 625 Dover Str

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Virginia
b. COUNTY Norfolk
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk
d. STREET ADDRESS 920 St. Paul St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First: EVA Middle: Mae Last: Thompson

4. DATE OF DEATH Month: 9 Day: 9 Year: 1959

5. SEX: Female
6. COLOR OR RACE: Col
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 12-3-1913
9. AGE (In years last birthday) 45 yrs.
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b KIND OF BUSINESS OR INDUSTRY: Factory
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Holloway
14. MOTHER'S MAIDEN NAME: Lucy Shorts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Francis Richardson, Boston, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH

162.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b) Squamous Cell Carcinoma

DUE TO (c) Bronchus → Liver etc

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m.; 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 4/18/59 to 9/9/59 that I last saw the deceased alive on 9/7/59, and that death occurred at 1130 M, from the causes and on the date stated above.

ACTUAL SIGNATURE L. H. Eglseder M.D.
ADDRESS (Street, city or town, state) 12 N. Hanson
DATE SIGNED

PHYSICIAN'S NAME (Type) L. H. Eglseder
EASTON Md

22a BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9-14-59
22c. NAME OF CEMETERY OR CREMATORY Calvary Cem
22d. LOCATION (City, town, or county) (State) Norfolk Va.

23. FUNERAL DIRECTOR'S SIGNATURE Hume-Bell Mill
ADDRESS Easton, Md.
24a. REC'D BY REGISTRAR DATE SEP 14 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10696 Reg. Dist. No. 10692

1. PLACE OF DEATH
a. COUNTY Talbot MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
c. LENGTH OF STAY IN 1b 4 days
d NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton
d STREET ADDRESS R.F.D. # 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First Edward Middle W. Last Towers
4. DATE OF DEATH Month September Day 13 Year 1959
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH January 1877
9. AGE (In years last birthday) 82 yrs.
IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer-Retired
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME William H. Towers
14 MOTHER'S MAIDEN NAME Pauline Burketts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Harry Towers Address Centerville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema
442 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Myocardial Insufficiency-coronary disease
DUE TO (c) Myocardiopathy
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:05 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE E.C.H. Schmidt M.D. ADDRESS (Street, city or town, state) 219 S. Washington St. Easton, Md. DATE SIGNED 9/16/59

PHYSICIAN'S NAME (Type) E.C.H. Schmidt Easton, Md. Maryland

22a BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9/16/59
22c. NAME OF CEMETERY OR CREMATORY Easton Memorial Hospital
22d. LOCATION (Town) (County) (State) Easton Md.

23 FUNERAL DIRECTOR'S SIGNATURE Ruth S. Kellogg ADDRESS E. N. Market
24a. REC'D BY REGISTRAR DATE SEP 21 '59
24b REGISTRAR'S SIGNATURE Catherine B. Kenna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2,9 Film 272 12-1-59 et

10709

CERTIFICATE OF DEATH

10693

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Talbot MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
c. LENGTH OF STAY IN 1b Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 2 Box 102

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
d. STREET ADDRESS Route # 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Amilia Middle W Last Ally
4. DATE OF DEATH Month 9 Day 7 Year 1959
5. SEX Female
6. COLOR OR RACE Col
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 12-15-89
9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife
10b. KIND OF BUSINESS OR INDUSTRY Domestic
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME James Bantom
14. MOTHER'S MAIDEN NAME Nancy Bantom
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Perry Wally

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocarditis
DUE TO (b) Acute Nephritis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 4-5 Years 3-4 mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from March 8 1959 to Sept 7 1959 that I last saw the deceased alive on Sept 7 1959 and that death occurred at 7:30 P. M. from the causes and an the date stated above.
ACTUAL SIGNATURE Maynard T. Kelly MD
ADDRESS (Street, city or town, state) 633 Dover St. Easton, Md.
DATE SIGNED
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9-12-59
22c. NAME OF CEMETERY OR CREMATORY Ivy town cem.
22d. LOCATION (City, town, or county) (State) Easton Rt 4 Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS James B Dashiell, Easton, Md.
24a. REC'D BY REGISTRAR DATE SEP 10 '59
24b. REGISTRAR'S SIGNATURE Arthur L Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as [illegible] please remove carbon papers. Pages 1 and 2 should be filed with

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10697

CERTIFICATE OF DEATH

10694
Reg. Dist. No.

M

080

I

1. PLACE OF DEATH a. COUNTY: Talbot, MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Caroline
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON · c. LENGTH OF STAY IN 1b: 5 da. 7 hrs 15 min.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Federalsburg 05 X 2
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hosp. at Easton	d. STREET ADDRESS: BUENA VISTA AVENUE · e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Robert M. Middle: B. Last: Wheatley	4. DATE OF DEATH Month: September Day: 15, Year: 1959

5. SEX: Fe	6. COLOR OR RACE: W	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: 11-5-1877 November 5, 1877	9. AGE (In years last birthday): 81 yrs.	IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.

USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: HOME	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? USA.

FATHER'S NAME: Robert Bradley	14. MOTHER'S MAIDEN NAME: Mary Catherine Noble

WAS DECEASED EVER IN U. S. ARMED FORCES? (… or unknown): No (If yes, give war or dates of service): —	16. SOCIAL SECURITY NO.: NONE	17. INFORMANT: W. LESLIE WHEATLEY Address: CLAYTON, DELAWARE

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cardiac failure	sudden
420.1 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	Myocardial infarction	5 days
DUE TO (c)	Atherosclerotic coronary thrombosis	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) · 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

0

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) · 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m. · 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ · 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) · 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10 Sept, 1959, to 15 Sept, 1959, that I last saw the deceased alive on 15 Sept, 1959, and that death occurred at 9:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thurston Harrison M.D. · ADDRESS (Street, city or town, state): Easton Maryland · DATE SIGNED: 16 Sept 59

PHYSICIAN'S NAME (Type): THURSTON HARRISON

1

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	22b. DATE THEREOF: SEPT. 18, 1959	22c. NAME OF CEMETERY OR CREMATORY: HILL CREST CEMETERY	22d. LOCATION (City, town, or county) (State): FEDERALSBURG, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: J.J. Frampton & Son, ADDRESS: Federalsburg, Maryland	24a. REC'D BY REGISTRAR DATE SEP 21 '59	24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

… been signed … the burial-transit permit. The … the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10698

CERTIFICATE OF DEATH

10695

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Talbot. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 4 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PRESTON - RURAL 05X-2
d. STREET ADDRESS: HARMONY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna Middle: Elizabeth Last: Williamson
4. DATE OF DEATH: Month: Sept. Day: 19 Year: 1959.

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 15th 1959
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months: Days: 4
IF UNDER 24 HRS.: Hours: 2 Min.: 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): U.S.a. EASTON, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.a.

13. FATHER'S NAME: Thomas Franklin Wells
14. MOTHER'S MAIDEN NAME: Pauline Kemp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT Address: PAULINE WILLIAMSON, PRESTON MARYLAND RFD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Multiple congential defects. — INTERVAL BETWEEN ONSET AND DEATH
759.3
DUE TO (b): 1. Cleft palate
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): 2. Meningo-myelocoele
3. Simple stenosis of heart.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 19, 19____, to Sept 19, 19____, that I last saw the deceased alive on Sept 19, 19____, and that death occurred at 5:22 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E.C.H. Schmidt M.D. ADDRESS (Street, city or town, state): 219 S. Washington St. Easton 16, Maryland DATE SIGNED: 19 Sept 59

PHYSICIAN'S NAME (Type): E.C.H. Schmidt

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: SEPT. 23, 1959
22c. NAME OF CEMETERY OR CREMATORY: HILL CREST CEMETERY
22d. LOCATION (City, town, or county) (State): FEDERALSBURG, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: J. J. Frampton & Son ADDRESS: Federalsburg Md
24a. REC'D BY REGISTRAR DATE: SEP 23 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

208192XU2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55